analyze the water for disinfection by-products and pesticides regulated pursuant to N.J.A.C. 7:10-5.

(c) Upon completion of construction of a water system, the owner of a nonpublic water system shall sample and analyze the raw water from the system for the parameters listed at (c)1 through [11] **12** below. The administrative authority may require sampling and analysis for inorganic chemicals, volatile organic compounds**,** and/or radionuclides**,** as appropriate**,** based on the region and the aquifer in which the water source is located.

1.-9. (No change.)

10. As of (18 months after the effective date of this amendment), the per- and polyfluoroalkyl substances PFNA, PFOA, and PFOS;

[10.] **11.** In addition to the parameters listed at (c)1 through [9] **10** above, if the water system is located in Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Monmouth, Ocean, or Salem County, mercury; and

[11.] **12.** In addition to the parameters listed at (c)1 through [9] **10** above, if the water system is located in Bergen, Essex, Hudson, Hunterdon, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex, Union, or Warren County, uranium.

(d)-(i) (No change.)

CHAPTER 14A
NEW JERSEY POLLUTANT DISCHARGE ELIMINATION SYSTEM

SUBCHAPTER 4. PERMIT APPLICATION REQUIREMENTS

APPENDIX A

PERMIT APPLICATION TESTING REQUIREMENTS/POLLUTANT LISTINGS

…

Table I-V (No change.)

Table VI

Toxic Pollutants and Hazardous Substances Required to be Identifed by Existing Dischargers if Expected to be Present

Per- and Polyfluoroalkyl Substances (PFAS)

Perfluorononanoic acid (PFNA)
Perfluorooctanoic acid (PFOA)
Perfluorooctanesulfonic acid (PFOS)

SUBCHAPTER 7. REQUIREMENTS FOR DISCHARGES TO [GROUNDWATER] **GROUND WATER** (DGW)

7:14A-7.9 General requirements for applications for discharge to [groundwater] **ground water** permit

(a) In addition to the information required pursuant to N.J.A.C. 7:14A-4.3, an applicant for a NJPDES Discharge to [Groundwater] **Ground Water** permit shall submit information to the Department as follows:

1. (No change.)

(b)-(c) (No change.)

(d) The following information shall be submitted in the application for the Discharge to Ground Water permit pursuant to (a) above:

1. (No change.)

2. Pollutant characteristics as follows:

i.-ii. (No change.)

iii. Characteristics of the quality of the discharge.

(1) Unless otherwise approved by the Department, all analyses or estimates shall include the following parameters at a minimum:

(A)-(Q) (No change.)

(R) Volatile organics; [and]

(S) Pesticides[.]**; and**

(T) Per- and Polyfluoroalkyl substances (PFAS).

(i) Perfluorononanoic acid (PFNA);

(ii) Perfluorooctanoic acid (PFOA); and

(iii) Perfluorooctanesulfonic acid (PFOS).

(2) Dependent on the nature of the facility as described in accordance with (d)1 above, base/neutral compounds, acid extractable compounds, volatile organics**, per- and polyfluoroalkyl substances (PFAS),** and pesticides shall be analyzed for as required pursuant to N.J.A.C. 7:14A-4 Appendix A; and

iv. (No change.)

3.-6. (No change.)

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Managed Health Care Services for Medicaid/NJ FamilyCare Beneficiaries

Proposed Readoption with Amendments: N.J.A.C. 10:74

Proposed Repeals: N.J.A.C. 10:74-3.6, 3.7, 3.8, and 8.4

Authorized By: Carole Johnson, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Agency Control Number: 18-P-09.

Proposal Number: PRN 2019-036.

Submit written comments by May 31, 2019, to:

Margaret M. Rose
Attn: Proposal 18-P-09
Division of Medical Assistance and Health Services
Office of Legal and Regulatory Affairs
Mail Code #26
PO Box 712
Trenton, NJ 08625-0712
Fax: (609) 588-7343
E-mail: Margaret.Rose@dhs.state.nj.us
Delivery: 6 Quakerbridge Plaza
Mercerville, NJ 08619

The agency proposal follows:

Summary

N.J.A.C. 10:74, Managed Health Care Services for Medicaid and NJ FamilyCare Beneficiaries, was scheduled to expire January 24, 2019, pursuant to N.J.S.A. 52:14B-5.1. This expiration date is extended 180 days to July 23, 2019, pursuant to N.J.S.A. 52:14B-5.1.c(2), because this notice of readoption was filed with the Office of Administrative Law prior to the expiration date. As the Division of Medical Assistance And Health Services ("Division" or "DMAHS") has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

The rules proposed for readoption regulate the enrollment of Medicaid and NJ FamilyCare beneficiaries into managed care as a health care delivery system and the provision of services by a managed care organization (MCO) to these beneficiaries. The Division has reviewed these rules and finds that they should be readopted with amendments because the rules are necessary, adequate, reasonable, efficient, understandable, and responsive to the purposes for which they were originally promulgated.

The rules proposed for readoption contain 15 subchapters, described as follows:

Subchapter 1, General Provisions, contains the purpose, authority, scope, definitions for the managed care rules, and rules regarding the pharmacy lock-in program.

Subchapter 2, Criteria for Contracting with the Department, contains the contracting requirements imposed on MCOs when they contract with the Department of Human Services ("DHS" or "Department").

Subchapter 3, Benefits, contains the scope of benefits; responsibilities of the contractor; managed care organization (MCO) benefits for Medicaid and NJ FamilyCare Plans A, B, and C enrollees; fee-for-service (FFS) program services requiring contractor assistance to the enrollee to access the services; services not requiring case management by the MCO; MCO services for NJ FamilyCare Plan D enrollees; fee-for-service benefits for NJ FamilyCare Plan D enrollees; benefits not provided for NJ FamilyCare Plan D enrollees; general Medicaid and NJ FamilyCare program limitations; general Medicaid and NJ FamilyCare program exclusions; reporting of services; and availability of services. The existing subchapter also contains sections regarding NJ FamilyCare Plan H, which are proposed for repeal as described below.

Subchapter 4, Marketing, contains requirements regarding marketing and the manner in which contractors may market services.

Subchapter 5, Information Provided to Enrollees, sets forth the information to be provided to enrollees by the contractor, which includes information regarding advance directives.

Subchapter 6, General Enrollment, contains enrollment information.

Subchapter 7, Disenrollment, pertains to disenrollment, in general, and disenrollment from an MCO.

Subchapter 8, Enrollees, contains requirements regarding mandatory managed care enrollment, enrollment exclusions, voluntary managed care enrollment (allowed and not allowed), reasons for exemptions from mandatory managed care, coverage prior to enrollment, coverage after enrollment, and protecting managed care enrollees against liability for payment.

Subchapter 9, Emergency Services, contains requirements regarding emergency services.

Subchapter 10, Medical Information and Quality Assurance, contains requirements for contractors regarding medical records, peer review, and quality assurance.

Subchapter 11, Grievance Procedure, sets forth the grievance procedure and fair hearing processes.

Subchapter 12, Reimbursement, sets forth contractor compensation, derivation of capitation rates, adjustment of capitation rates, payment of capitation to contractors, coverage of hospitalized persons, and situations where no payment will be made.

Subchapter 13, General Reporting Requirements, contains the reporting requirements for contractors.

Subchapter 14, Contract Sanctions, contains contract sanctions.

In anticipation of this notice of rules proposed for readoption with amendments and repeals, an advance notice of rulemaking was distributed to a list of interested parties that is maintained by the Division. Two comment letters were received in response to that notice. Comments were received from the New Jersey Association of Long Term Care Pharmacy Providers (NJALTCPP) and the New Jersey Hospital Association (NJHA).

The NJALTCPP suggested that beneficiaries who are locked in to using one pharmacy be able to have that restriction lifted upon admission to a long-term care facility, so that the facility can fill the prescriptions using their pharmacy. The Division agrees that is a reasonable request and language is proposed to indicate that this exception to the lock-in program would be allowed. The commenter also suggested allowing subcontractors hired by the managed care contractor to hire subcontractors themselves. This change is not proposed, as secondary subcontracting is not permissible in the managed care contract. The Department limits the authority to hire subcontractors to the managed care organization under contract with the Department as part of an overall approach to ensuring quality care is provided to beneficiaries directly from the MCO with not more than one level of separation between the Department and the actual provider of care.

NJHA's comments addressed issues with the negotiations of the MCO contracts and the State's requirements related to the adequacy of the MCO's network; the adoption and implementation of the policies of the Centers for Medicare and Medicaid Services (CMS) by the MCO; the functionality of the State's claims system and processes with regard to the denial of claims; and the processes for the reporting of MCO data to the State. Addressing NJHA's concerns will require further discussion and any changes would need to be addressed either in the specific contracts, in the rules, or both, as appropriate. Considering the time needed to adequately discuss these comments and determine what, if any, action will be taken, it is not feasible to address them as part of this rulemaking. After consideration and discussion, any changes determined necessary in response to NJHA's comments would be addressed in a future rulemaking.

Summary of General Amendments

Throughout the chapter, references to "Medicaid and NJ FamilyCare," "Medicaid or NJ FamilyCare," or "Medicaid" are proposed for amendment to "Medicaid/NJ FamilyCare" to be consistent with the nomenclature used by DMAHS when referring to the program.

Throughout the chapter, references to the Department of Health and Senior Services or DHSS are proposed for amendment to Department of Health or DOH to reflect the correct name of the Department.

Throughout the chapter, references to the Division of Youth and Family Services or DYFS are proposed for amendment to Division of Child Protection and Permanency or CP&P to reflect the correct name of the component of the Department of Children and Families.

Summary of Specific Amendments

At N.J.A.C. 10:74-1.2, proposed amendments delete existing subsections (a) and (b), which describe the Federal authority for the use of managed care organizations to provide managed medical care services to beneficiaries. These provisions have not been updated since 2006 and are outdated. These provisions are being replaced with proposed new subsection (a) that sets forth the current Federal authority for the use of managed care organizations to provide managed medical care services to beneficiaries.

At N.J.A.C. 10:74-1.4, the following definitions are proposed to be added: "behavioral health services," "Child Protection and Permanency (CP&P)," "Comprehensive Waiver," "managed long-term services and supports (MLTSS)," and "NJ FamilyCare Alternative Benefit Plan (ABP)."

At N.J.A.C. 10:74-1.4, the following definitions are proposed to be deleted: "Division of Youth and Family Services (DYFS)" and "NJ FamilyCare-Plan D for Adults."

At N.J.A.C. 10:74-1.4, a proposed amendment to the definition of "Commissioner" and "Department" specifies that office is for the "New Jersey" Department of Human Services.

At N.J.A.C. 10:74-1.4, a proposed amendment to the definition of "Medicaid beneficiary" adds references to N.J.A.C. 10:78 and 10:79, in addition to the standard amendments discussed above.

At N.J.A.C. 10:74-1.4, a proposed amendment to the definition of "NJ FamilyCare-Plan D" removes references to parents and caretakers because they are no longer covered under this plan. Eligible parents and caretakers of children enrolled in NJ FamilyCare are covered under "NJ FamilyCare-Plan D for adults" in accordance with N.J.A.C. 10:49 and 10:78.

At N.J.A.C. 10:74-1.4, a proposed amendment to the definition of "subcontractor" indicates that a subcontractor cannot further subcontract the obligations that it agreed to provide for the contractor.

The heading of N.J.A.C. 10:74-1.5 is proposed for amendment to "Provider lock-in program ..." because this program will no longer apply to only pharmacies, but to all provider types, so that beneficiaries will not be able to access duplicate services by going to multiple providers for the same condition.

At N.J.A.C. 10:74-1.5(a), proposed amendments change "pharmacy" to "provider" and states that the managed care contractor may implement a lock-in program that restricts enrollees to using a single provider for a reasonable amount of time.

At N.J.A.C. 10:74-1.5(a)1, a proposed amendment changes "pharmacy" to "provider."

At N.J.A.C. 10:74-1.5(a)2, a proposed amendment clarifies that the restriction to a single provider does not apply in emergency situations.

Proposed new N.J.A.C. 10:74-1.5(a)3 states that the lock-in restriction shall not apply if the beneficiary is receiving inpatient services but shall continue upon discharge from the inpatient facility.

Recodified N.J.A.C. 10:74-1.5(a)4 and 7 are proposed for amendment to change "pharmacy" to "provider."

At N.J.A.C. 10:74-3.1(b), a proposed amendment removes the reference to NJ FamilyCare-Plan D. Effective July 1, 2018, NJ FamilyCare-Plan D beneficiaries have been receiving the standard service package and, therefore, do not need to be excluded from this rule.

At N.J.A.C. 10:74-3.2(c)1, a proposed amendment adds NJ FamilyCare-Plan D, to indicate that Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services shall be limited to services covered under the managed care contract for NJ FamilyCare-Plan D because NJ FamilyCare-Plan D enrollees now receive the standard benefit package.

N.J.A.C. 10:74-3.3 is proposed for amendment to add Plan D enrollees because NJ FamilyCare-Plan D enrollees now receive the standard benefit package. There are some exceptions to the benefit package as detailed in subsequent sections of this rule; these exceptions are described below.

At N.J.A.C. 10:74-3.3(a)26, proposed amendments clarify that nursing facility (NF) and special care nursing facility (SCNF) services are covered for NJ FamilyCare Plan A and ABP enrollees and that only rehabilitation services are available to those enrolled in NJ FamilyCare Plans B, C, and D when they are in a NF or SCNF.

At N.J.A.C. 10:74-3.3(a)27, proposed amendments change the term "substance abuse" to "substance use disorder," the term used by the professional community; state that mental health and substance use disorder services shall only be provided for MLTSS enrollees and those enrollees who are also clients of the Division of Developmental Disabilities (DDD) or enrolled in a Fully Integrated Dual Special Needs Program (FIDE-SNP) program; and remove the last sentence regarding partial care and partial hospitalization services being provided on a fee-for-service basis only because those services have been the responsibility of the MCO since January 2018.

Proposed new N.J.A.C. 10:74-3.3(a)28 adds partial care and partial hospitalization to the package of services provided by the MCO. Division of Developmental Disabilities clients do not receive these services from the MCO.

Proposed N.J.A.C. 10:74-3.3(a)29 adds inpatient mental health and substance use disorder treatment to the services included in the package of services provided by the MCO.

N.J.A.C. 10:74-3.4 is proposed for amendment to add Plan D enrollees because NJ FamilyCare-Plan D enrollees now receive the standard benefit package. The services set forth in this section are provided to Plans A, B, C, and D enrollees through the Medicaid/NJ FamilyCare fee-for-service program and may require MCO assistance to the enrollee, such as providing medical orders, in order to assist the enrollee to access the services.

At N.J.A.C. 10:74-3.4(a) is proposed to clarify that the MCO may provide assistance, including, but not limited to, actions such as providing medical orders, in order to aid the enrollee in accessing care.

At N.J.A.C. 10:74-3.4(a)1 and 2, a proposed amendment clarifies that personal care assistant services and medical day care services, respectively, are not available to enrollees of NJ FamilyCare-Plans B, C, or D unless the individual is enrolled in Managed Long-Term Services and Supports (MLTSS).

At N.J.A.C. 10:74-3.4(a)3, a proposed amendment deletes the time limits for rehabilitation services for Plans B and C.

At N.J.A.C. 10:74-3.4(a)5, a proposed amendment deletes the reference to NJ FamilyCare-Plans B and C since all plans are eligible to receive lower mode transportation.

N.J.A.C. 10:74-3.5 is proposed for amendment to add Plan D enrollees because NJ FamilyCare-Plan D enrollees now receive the standard benefit package. There are some exceptions to the standard benefit package and those exceptions are described below.

Existing N.J.A.C. 10:74-3.5(a)2 and 3 are proposed to be deleted since the services discussed in these paragraphs are only available to NJ FamilyCare-Plan A. New language will be proposed as N.J.A.C. 10:74-3.5(b) to address this.

Recodified N.J.A.C. 10:74-3.5(a)2 and 3 are proposed for amendment to indicate that while outpatient mental health services for individuals and outpatient substance use disorder services for individuals, respectively, who are DDD clients or who are enrolled in either MLTSS or a Fully Integrated Dual Special Needs Program (FIDE-SNP) are eligible for case management services from the MCO, all other categories of enrollees shall receive their outpatient mental health services fee-for-service and shall not require case management services from the MCO.

Recodified N.J.A.C. 10:74-3.5(a)4 and 5 are proposed for amendment to include minor technical and grammatical corrections.

Existing N.J.A.C. 10:74-3.5(a)8 is proposed for deletion because these services are now paid for under managed care, not fee-for-service.

Existing N.J.A.C. 10:74-3.5(a)9 is proposed for deletion since the services discussed in this paragraph is only available to NJ FamilyCare Plan A and under the Alternative Benefit Package. New language will be proposed as N.J.A.C. 10:74-3.5(b) to address this.

Proposed new N.J.A.C. 10:74-3.5(b) lists services that shall be provided to NJ FamilyCare-Plan A beneficiaries through the Medicaid/NJ FamilyCare fee-for-service program without requiring case management by the MCO.

Proposed new N.J.A.C. 10:74-3.5(b)1 lists intermediate care facilities/individuals with intellectual disabilities (ICF/IID) services.

Proposed new N.J.A.C. 10:74-3.5(b)2 lists waiver and demonstration program services.

Proposed new N.J.A.C. 10:74-3.5(b)3 lists the Community Care Program (CCP), which provides services to DDD clients over age 21 who receive NJ FamilyCare-Plan A or the Alternative Benefit Package.

N.J.A.C. 10:74-3.6, Managed care organization (MCO) services for NJ FamilyCare-Plan D enrollees, 3.7, Fee-for-service benefits for NJ FamilyCare-Plan D enrollees, and 3.8, Benefits not provided for NJ FamilyCare-Plan D enrollees, are proposed for repeal because all plans now receive a standard services package as described above.

At N.J.A.C. 10:74-7.1(a)3, the reference to a "DYFS Residential Treatment Center" is proposed for deletion because these facilities have all been closed; additionally, the references to "ICF/MR" and long-term psychiatric facilities are proposed to be deleted. Disenrollment from these facilities is discussed below at N.J.A.C. 10:74-7.1(e) and they do not need to be listed in both locations.

At N.J.A.C. 10:74-7.1(a)6, a proposed amendment indicates that an NJ Medicaid/FamilyCare beneficiary who was determined eligible for benefits under the NJ FamilyCare-Children's Program will be disenrolled upon reaching 19 years of age.

At N.J.A.C. 10:74-7.1(e), proposed amendments remove the requirement that beneficiaries receiving services in a waiver or demonstration program, or treatment in a nursing facility (NF), for more than 30 days and/or beneficiaries who are enrolled into a waiver or demonstration program at the end of their 30th day in an NF, be subject to disenrollment from the MCO because long-term care services are provided by the Comprehensive Waiver and are included in the managed care package. The language will now only require that beneficiaries who are admitted to a long-term psychiatric facility or an ICF/IID, be disenrolled upon the date of admission to the facility because case management is provided by the staff of those facilities and continuing to pay the capitation rate to the MCO while paying fee-for-service in the long-term psychiatric facility or ICF/IID is a duplication of services and not cost-effective. Additionally, the reference to "ICF/MR" has been changed to "ICF/IID" to reflect the correct name of the facilities.

N.J.A.C. 10:74-8.2(a)1 and 2 are proposed for deletion because the waiver and demonstration programs listed have all been combined into the Comprehensive Waiver and all enrollees are enrolled in managed care.

Recodified N.J.A.C. 10:74-8.2(a)2 is proposed for amendment to delete the reference to the "Home Care Expansion Program," since that program no longer exists.

Existing N.J.A.C. 10:74-8.2(a)6 is proposed to be deleted because individuals already enrolled in or covered by a Medicare or private MCO that does not have a contract with the Department to provide Medicaid services will no longer be excluded from enrollment in the Medicaid/NJ FamilyCare managed care program.

N.J.A.C. 10:74-8.2(a)10 is proposed for deletion because individuals classified as "DYFS Code 65 Individuals" will no longer be excluded from enrollment in the managed care program. This code refers to children under the supervision of DYFS (now known as CP&P) who were in regional treatment centers prior to the implementation of the MLTSS benefit package on July 1, 2014.

N.J.A.C. 10:74-8.4, Reasons for exemptions from mandatory managed care, is proposed for repeal because exemptions from mandatory managed care are no longer allowed.

Proposed new N.J.A.C. 10:74-10.2(c)1 requires a contractor who is hiring a subcontractor to fulfill obligations of the MCO's contract with the State to include in the written agreement with the subcontractor that the subcontractor shall not, in turn, subcontract any of its obligations to the contractor.

Social Impact

During State Fiscal Year 2018, a monthly average of 1,670,542 Medicaid/NJ FamilyCare beneficiaries received health services through managed care. The program improves the quality of life for beneficiaries who require healthcare services because the MCOs are able to provide a comprehensive package of preventive health services. The rules proposed for readoption with amendments and repeals regulate the managed care program in order to provide health care services to those who otherwise might not be able to afford these services.

The rules proposed for readoption with amendments and repeals will have a positive social impact on Medicaid and NJ FamilyCare beneficiaries and providers because continued coverage of managed care services to these beneficiaries by the providers will be assured. Without such services, the health of the beneficiaries would suffer, because they would have no other resource for health care beyond the safety net services provided by health center clinics.

The proposed repeal of N.J.A.C. 10:74-3.6, 3.7, and 3.8 reflects that NJ FamilyCare-Plan D beneficiaries now receive a standard benefit package; this has improved the services available to the beneficiaries eligible under the criteria of NJ FamilyCare-Plan D.

The proposed repeal of N.J.A.C. 10:74-8.4 reflects that there are no longer exemptions from enrolling in managed care. Managed care provides a comprehensive and coordinated approach to providing medical care and services to their enrollees, ensuring that the most appropriate level of care is provided.

The MCOs that participate in the Medicaid/NJ FamilyCare programs providing managed healthcare services are: Aetna Better Health of New Jersey, Amerigroup New Jersey Inc., Horizon NJ Health, United Healthcare Community Plan, and WellCare.

The rules proposed for readoption with amendments and repeals will have a positive impact on the providers and beneficiaries because they address Federal and State mandates regarding the provision of services, update the rule text to ensure consistency with the requirements of the contract between DHS/DMAHS and the MCOs, provide updates to existing text to ensure the accuracy of definitions and citations, and expand explanatory language. This will, in turn, make the requirements and benefits of the programs easier to understand and comply with for those providers and beneficiaries.

Economic Impact

During State Fiscal Year 2018, total managed care expenditures were $9.915 billion gross, $3.505 billion State share.

The rules proposed for readoption with amendments and repeals, as described in the Summary above, should not change overall annual costs to the managed care organizations or the State. The rules proposed for readoption with amendments and repeals will have a positive economic impact on managed care providers and Medicaid/NJ FamilyCare beneficiaries because the providers will continue to be reimbursed for services that Medicaid/NJ FamilyCare beneficiaries might not otherwise be able to afford and beneficiaries will continue to receive medically necessary healthcare services without paying for the services themselves beyond already existing cost-sharing and co-payments for some NJ FamilyCare plans.

The proposed amendments and repeals will have a positive impact on the providers and beneficiaries because they update the rule text to ensure consistency with the requirements of the contract, provide updates to existing text to ensure the accuracy of definitions, and expand explanatory language. This will, in turn, make the requirements and benefits of the programs easier to understand and comply with for those providers and beneficiaries, which will allow them to navigate the programs in a more efficient manner.

Federal Standards Statement

Section 1932 of the Social Security Act, 42 U.S.C. § 1396u-2, enumerates provisions relating to managed health care services and grants a state Medicaid program the option to use MCOs to provide medical assistance to eligible individuals. New Jersey has elected to provide managed care services to eligible beneficiaries. The statute also elaborates on the choice of coverage by eligible individuals; details the process of enrollment, termination, and change of enrollment; enumerates the rights of beneficiaries; itemizes information that must be given by providers to beneficiaries; spells out protections and sanctions for non-compliance of managed care entities; and assures coverage of medically necessary emergency services.

Section 1903(m)(1)(A) of the Social Security Act, 42 U.S.C. § 1396b(m)(1)(A), defines a Medicaid managed care organization and requires the managed care organization to provide the same access to both Medicaid and non-Medicaid beneficiaries; make adequate provision against the risk of insolvency for a non-governmental entity; and specifies requirements in the managed care organization's contract regarding its financial relationship with a state and the responsibility for managed care payments to beneficiaries.

Pursuant to Section 1915(b) of the Social Security Act, 42 U.S.C. § 1396n(b), a state Medicaid program may secure approval from the Centers for Medicare & Medicaid Services (CMS) for a 1915(b) waiver that would allow that state to limit the choice of providers and require particular groups of beneficiaries to enroll in a managed care plan for medical coverage. New Jersey has secured such a waiver regarding special needs children.

Title XXI of the Social Security Act allows states the option of establishing a State Children's Health Insurance Program (SCHIP) for targeted low-income children and where states elect to utilize the option, provides guidelines for coverage and eligibility. See Sections 2101 through 2110, 42 U.S.C. §§ 1397aa through 1397jj. New Jersey elected this option through implementation of the NJ FamilyCare Children's Program.

Federal standards for a qualified health maintenance organization (HMO) are contained in 42 U.S.C. § 300e-9(c).

Federal standards for MCOs are also found at 42 CFR Part 438. Conditions necessary to contract as a managed care entity (MCE) are specified at 42 CFR 457.955.

The Department has reviewed the Federal statutory and regulatory requirements and has determined that the rules proposed for readoption with amendments and repeals do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

Jobs Impact

The Department does not anticipate that the rules proposed for readoption with amendments and repeals will have an impact on employment in the State of New Jersey and does not expect that any jobs will be gained or lost as a result of these rules.

Agriculture Industry Impact

Since the rules proposed for readoption with amendments and repeals concern the provision of managed care organization services to Medicaid and NJ FamilyCare beneficiaries, the Department anticipates that the rules will have no impact on the agriculture industry in the State of New Jersey.

Regulatory Flexibility Statement

The providers affected by the rules proposed for readoption with amendments and repeals are all managed care organizations that have more than 100 full-time employees. Therefore, they are not considered small businesses, as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., and a regulatory flexibility analysis is not required.

Housing Affordability Impact Analysis

Since the rules proposed for readoption with amendments and repeals concern the provision of managed care organization services to Medicaid and NJ FamilyCare beneficiaries, the Department anticipates that the rules will have no impact on the affordability of housing in New Jersey and there is no likelihood that the rules would evoke a change in the average costs associated with housing.

Smart Growth Development Impact Analysis

Since the rules proposed for readoption with amendments and repeals concern the provision of managed care organization services to Medicaid and NJ FamilyCare beneficiaries, the Department anticipates that there is no likelihood that the rules would evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan in New Jersey.

Racial and Ethnic Community Criminal Justice and Public Safety Impact

The Department has evaluated this rulemaking and determined that it will not have an impact on pretrial detention, sentencing, probation, or parole policies concerning adults and juveniles in the State. Accordingly, no further analysis is required.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 10:74.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 10:74-3.6, 3.7, 3.8, and 8.4.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

CHAPTER 74
MANAGED HEALTH CARE SERVICES FOR [MEDICAID AND NJ] **MEDICAID/NJ** FAMILYCARE BENEFICIARIES

SUBCHAPTER 1. GENERAL PROVISIONS

10:74-1.1 Purpose

The rules in this chapter set forth the manner in which the New Jersey [Medicaid and NJ] **Medicaid/NJ** FamilyCare programs shall provide covered health services to eligible persons through the Managed Care program, by means of managed care organizations (MCOs).

10:74-1.2 Authority

[(a) Under section 1915(b) of the Social Security Act (42 U.S.C. § 1396n(b), the State Medicaid program may request a waiver to provide medical services through a managed care organization to Medicaid and NJ FamilyCare -Plan A beneficiaries, on less than a Statewide implementation basis, to restrict an individual's freedom to receive medical services solely from his/her elected managed care organization, and to allow the Medicaid and NJ FamilyCare-Plan A programs to require certain beneficiaries to select a managed care organization to provide their medical services.

(b) The State Medicaid program may also elect to provide managed care services as a State Plan optional service under section 1932(a) of the Social Security Act (42 U.S.C. § 1396u-2(a)). New Jersey has implemented this option.]

(a) The State Medicaid program provides managed medical services under the authority of the New Jersey 1115 demonstration project entitled "New Jersey FamilyCare Comprehensive Demonstration" and under Section 1932(a) of the Social Security Act (42 U.S.C. § 1396u-2(a)).

[(c)] **(b)** (No change in text.)

10:74-1.3 Scope

(a) The provisions within this chapter affect [Medicaid and NJ] **Medicaid/NJ** FamilyCare beneficiaries.

(b) The rules in this chapter also affect [Medicaid and NJ] **Medicaid/NJ** FamilyCare providers, including managed care entities and those providers who will continue to provide certain services on a fee-for-service basis to beneficiaries who are also enrolled in managed care.

10:74-1.4 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

…

"AIDS Drug Distribution Program (ADDP)" means the Department of Health [and Senior Services (DHSS)] **(DOH)** program**,** which provides life-sustaining and life-prolonging medications to persons who are HIV-positive, or who are living with AIDS, and who meet residency and income criteria for program participation.

…

"Behavioral health services" refers to the treatment and amelioration of behavioral/mental health conditions, as well as efforts to prevent and intervene in substance use disorder.

…

"Child Protection and Permanency" (CP&P) means the component of the New Jersey Department of Children and Families (DCF), which provides comprehensive social services for children, families, and adults. CP&P beneficiaries who are eligible for Medicaid/NJ FamilyCare are financially eligible children in foster care or other State-supported placements under the supervision of CP&P and children who have been placed in private adoption agencies until they are legally adopted or in subsidized adoptions.

…

"Commissioner" means the Commissioner of the **New Jersey** Department of Human Services or a duly authorized representative.

…

"Comprehensive Waiver" means the New Jersey 1115 Comprehensive Waiver Demonstration that consolidated several previously existing Medicaid waivers for the purpose of:

1. Integrating primary care, acute care, behavioral health care, and long-term services and supports;

2. Providing a wide array of services to individuals with intellectual or developmental disabilities who are living at home with their families;

3. Increasing community-based services for children who are dually diagnosed with developmental disabilities and mental illness by providing case management and behavioral and individual supports; and

4. Expanding managed care to individuals in need of long-term services and supports, diverting more individuals from institutional placement through increased access to home and community-based services (HCBS).

…

"Contractor's plan" means all services and responsibilities undertaken by the contractor pursuant to this chapter concerning managed health care services for [Medicaid and NJ] **Medicaid/NJ** FamilyCare beneficiaries.

"County welfare agency (CWA)," formerly known as "county board of social services (CBOSS)," means that agency of county government that is responsible for determining eligibility for certain [Medicaid and NJ] **Medicaid/NJ** FamilyCare programs. CWA is the general term for the county agency; depending on the county, the CWA might be identified as the Board of Social Services, the Welfare Board, the Division of Welfare, or the Division of Social Services.

…

"Department" means the **New Jersey** Department of Human Services.

…

"Department of Health [and Senior Services (DHSS)]" **(DOH)** means the New Jersey Department of Health [and Senior Services].

…

"Disenrollment" means the process of removal of an enrollee from the contractor's plan, not from the [Medicaid or NJ] **Medicaid/NJ** FamilyCare programs.

…

["Division of Youth and Family Services (DYFS)" means the component of the New Jersey Department of Children and Families, which provides comprehensive social services for children, families and adults. DYFS beneficiaries who are eligible for Medicaid or NJ FamilyCare are financially eligible children in foster care or other State-supported placements who are under the supervision of DYFS, and children who have been placed in private adoption agencies until they are legally adopted or in subsidized adoptions.]

"Dually eligible individual" means an individual who is eligible for both Medicare and [Medicaid] **Medicaid/NJ FamilyCare**.

…

"Enrollee" or "enrolled beneficiary" means an individual residing within the defined enrollment area, who elects or has had elected on his or her behalf by an authorized person, in writing, to participate in the specific contractor's plan, whether through the mandatory managed care coverage or on an individual, voluntary basis, and who meets specific

[Medicaid or NJ] **Medicaid/NJ** FamilyCare eligibility requirements for Plan enrollment agreed to by the Department and the contractor, at N.J.A.C. 10:74-6.

"Enrollment," for the mandatory managed health care program, means the process whereby specified [Medicaid and NJ] **Medicaid/NJ** FamilyCare-Plan A beneficiaries are required to join an MCO to receive health services, unless otherwise exempted or excluded. All other NJ FamilyCare beneficiaries, except for certain newborns, are not exempt from mandatory enrollment.

"Enrollment" for the voluntary program means the process by which certain [Medicaid and NJ] **Medicaid/NJ** FamilyCare-Plan A eligible individuals voluntarily enroll in an MCO for the provision of health services and by which such application is approved.

…

"Enrollment lock-in period" means the period between the first day of the fourth month and the end of 12 months after the effective date of enrollment in the contractor's plan, during which time the enrollee shall have good cause in order to disenroll or transfer from the contractor's plan. The enrollment lock-in period is not construed as a guarantee of eligibility during the lock-in period. Lock-in provisions do not apply to clients of DDD or SSI, New Jersey Care … Special Medicaid Program—Aged, Blind, Disabled, and [DYFS] **CP&P** enrollees.

…

"Excluded services" means services covered under the fee-for-service [Medicaid or NJ] **Medicaid/NJ** FamilyCare programs that are not included in the managed care benefit package.

…

"Health benefits coordinator (HBC)" means an entity under contract with the Department whose primary responsibility is to assist [Medicaid and NJ] **Medicaid/NJ** FamilyCare-eligible enrollees in the selection of and enrollment in a managed care plan.

…

"Health maintenance organization (HMO)" means a public or private organization, organized under State law**,** which:

1. (No change.)

2. Meets the Division's definition of an HMO**,** which includes, at a minimum, the following requirements:

i. (No change.)

ii. Makes the services it provides to its [Medicaid] **Medicaid/NJ FamilyCare** enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to non-enrolled [Medicaid] **Medicaid/NJ FamilyCare** eligible individuals within the area served by the HMO;

iii. Makes provision against the risk of insolvency, and assures that [Medicaid] **Medicaid/NJ FamilyCare** enrollees will not be liable for the HMO's debts if it does become insolvent; and

iv. (No change.)

…

"Lower mode transportation" means curb-to-curb car or van transportation provided to [Medicaid] **Medicaid/NJ FamilyCare** beneficiaries who are ambulatory and who do not require assistance or supervision to travel to and from their medical appointments.

…

"Managed care organization (MCO)" means an entity that has, or is seeking to qualify for, a comprehensive risk contract, and that is:

1. (No change.)

2. A public or private entity that meets the advance directives requirements of 42 CFR Part 489, Subpart I**,** incorporated herein by reference, as amended and supplemented**,** and is determined to meet the following conditions:

i. Makes the services it provides to its [Medicaid] **Medicaid/NJ FamilyCare** enrollees equally accessible (in terms of timeliness, amount, duration, and scope) as those services [which] **that** are provided to other [Medicaid] **Medicaid/NJ FamilyCare** beneficiaries within the area served by the entity; and

ii. (No change.)

…

"Managed long-term services and supports (MLTSS)" means services that are provided under the New Jersey 1115 Comprehensive Waiver through Medicaid/NJ FamilyCare MCO plans, the purpose of which is to support clients who meet nursing home level of care in the most appropriate setting to meet their specific needs, allowing them to remain at home in the community instead of living in a nursing facility.

1. Individuals qualify for MLTSS by meeting established Medicaid financial requirements and Medicaid clinical and age and/or disability requirements for nursing facility services contained at N.J.A.C. 10:69, 70, 71, or 72.

2. For children who meet the nursing home level of care, and who are applying for MLTSS, there is no deeming of parental income or resources in the determination of eligibility.

3. Once qualified to receive MLTSS, the individual must be enrolled with a managed care organization (MCO) in order to receive MLTSS services.

…

"Marketing" means any activity by**,** or means of communication from**,** the MCO, its employees, affiliated providers, subcontractors, or agents, or on behalf of the MCO by any person, firm**,** or corporation, by which information about the MCO's plan is made known to [Medicaid or NJ] **Medicaid/NJ** FamilyCare eligible persons that can reasonably be interpreted as intended to influence the individual to enroll in the MCO's plan or either to not enroll in, or to disenroll from, another MCO's plan.

…

"[Medicaid] **Medicaid/NJ FamilyCare** beneficiary" means an individual eligible to receive services under the New Jersey Medicaid **fee-for-service** program **or any NJ FamilyCare plan** in accordance with N.J.A.C. 10:69, 10:70, 10:71, [or] 10:72**, 10:78, or 10:79**.

"Medically necessary services" means services or supplies necessary to prevent, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate to individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the treatment, the type of provider and the setting, are reflective of the level of services that can be safely provided, are consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. Course of treatment may include mere observation or, where appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are deemed not medically necessary. Medically necessary services provided are based on peer-reviewed publications, expert pediatric, psychiatric, and medical opinion, and medical/pediatric community acceptance. In the case of pediatric enrollees, this definition applies, with the additional criteria that the services, including those found to be needed by a child as a result of a comprehensive screening visit or an inter-periodic encounter, whether or not they are ordinarily covered services for all other [Medicaid] **Medicaid/NJ FamilyCare** enrollees, are appropriate for the age and health status of the individual and that the service will aid the overall physical and mental growth and development of the individual and the service will assist in achieving or maintaining functional capacity.

…

"Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)" means the Federal law ([P.L.] **Pub. L.** 110-343), which provides participants who already have benefits under mental health and substance use disorder (MH/SUD) coverage parity with benefits limitations under their medical/surgical coverage. [Medicaid] **Medicaid/NJ FamilyCare** managed care organizations are subject to the MHPAEA statute.

"Multilingual" means, at a minimum, English and Spanish plus any other language [which] **that** is spoken by 200 enrollees or five percent or

more of the enrolled [Medicaid] **Medicaid/NJ FamilyCare** population in the contractor's plan, whichever is greater.

…

"NJ FamilyCare Alternative Benefit Plan (ABP)" means the eligibility package that provides comprehensive, managed care coverage to parents of dependent children, and single or married adults without dependent children. The beneficiary must be between the ages 19 to 64 and have an income between the AFDC standard set forth at N.J.A.C. 10:69-10 and 138 percent of the Federal poverty level.

…

"NJ FamilyCare-Plan D" means the State-operated program [which] **that** provides managed care coverage to uninsured[:] children below the age of 19 with family incomes above 200 percent and up to and including 350 percent of the FPL[, parents/caretakers with children below the age of 19 who do not qualify for AFDC-Related Medicaid with family incomes up to and including 200 percent of the FPL, to enrollees who were formerly in the Health Access program and parents/caretakers with children below the age of 23 years and children from the age of 19 through 22 years who are full time students who do not qualify for AFDC-Related Medicaid with family incomes up to and including 250 percent of the FPL]. In addition to covered managed care services, Plan D enrollees may access certain services [which] **that** are paid fee-for-service and not covered by MCOs, as specified in this chapter. Plan D enrollees with incomes above 150 percent of the FPL, except American Indians and Alaska Natives (AI/AN) below the age of 19, participate in cost-sharing in the form of monthly premiums and copayments for services, as specified in this chapter.

["NJ FamilyCare-Plan D for adults" means the State-operated program, which provides a benefit package through managed care organizations, supplemented by services provided on a fee-for-service basis, to specified parents/caretakers of children enrolled in NJ FamilyCare, in accordance with N.J.A.C. 10:49 and 10:78.]

…

"Non-covered [Medicaid] **Medicaid/NJ FamilyCare** services" means all services not covered under the New Jersey State Plan for the [Medicaid] **Medicaid/NJ FamilyCare** program.

…

"Out-of-area services" means all services covered under the contractor's benefits package included under the terms of the [Medicaid and/or NJ] **Medicaid/NJ** FamilyCare contract [which] **that** are provided to enrollees outside the defined service area.

"Out-of-plan services" means [Medicaid or NJ] **Medicaid/NJ** FamilyCare covered services [which] **that** have not been included in the contractor's benefits package. These services are provided under a fee-for-service arrangement through the Division to Medicaid beneficiaries and certain NJ FamilyCare beneficiaries who have enrolled in an MCO.

…

"Service area" means the geographic area in which the contractor is obligated to provide covered services for its [Medicaid and/or NJ] **Medicaid/NJ** FamilyCare enrollees under its contract.

…

"Standard service package" means the list of services, and any limitations thereto, which are required to be provided by managed health care providers to [Medicaid or NJ] **Medicaid/NJ** FamilyCare beneficiaries. These packages differ by program.

…

"Subcontractor" means any third party who has a written agreement with the contractor to perform a specified part of the contractor's obligations **to the State**, and is subject to the same terms, rights, and duties as the contractor. **A subcontractor shall not subcontract any obligations contained in its written agreement with the contractor.**

…

"Target population" means the population from which the initial number of enrollees, not to exceed any limit specified in the contract, will be drawn; that is, individuals eligible for [Medicaid or NJ] **Medicaid/NJ** FamilyCare residing within the stated enrollment area and belonging to one of the categories of eligibility for [Medicaid or NJ] **Medicaid/NJ** FamilyCare to be covered under the contract.

"Termination" means the loss of [Medicaid or NJ] **Medicaid/NJ** FamilyCare eligibility and, therefore, automatic disenrollment of the beneficiary from the MCO.

"[Third party] **Third-party** liability (TPL)" means another party or entity, such as an insurance company, which is, or may be, responsible to pay for all or a part of the health care costs of a [Medicaid or NJ] **Medicaid/NJ** FamilyCare-Plan A beneficiary.

…

10:74-1.5 [Pharmacy] **Provider** lock-in program under managed care

(a) The managed care contractor may implement a [pharmacy] lock-in program [for] **that restricts** its enrollees **to a single pharmacy and/or other provider type for a reasonable period of time**. The program shall include policies, procedures**,** and criteria for establishing the need for the lock-in, which shall be prior approved by DMAHS and shall include the following components to the program:

1. Enrollees shall be notified prior to the lock-in and shall be permitted to choose or change [pharmacies] **providers** for good cause;

2. **The lock-in restrictions do not apply to emergency services furnished to the enrollee.** A 72-hour emergency supply of medication at pharmacies other than the designated lock-in pharmacy shall be permitted to assure the provision of necessary medication required in an interim/urgent basis when the assigned pharmacy does not immediately have the medication;

3. The lock-in restriction shall not apply while the beneficiary is receiving services on an inpatient basis, including, but not limited to, medical and pharmacy services provided in a hospital, rehabilitation facility, or nursing facility. Upon discharge from the inpatient facility, the beneficiary shall resume accessing services from the pharmacy and/or provider previously designated by the lock-in program.

[3.] **4.** Care management and education reinforcement of appropriate [medication/pharmacy] **medication/provider** use shall be provided. A plan for an education program for enrollees shall be developed and submitted to the Division for review and approval;

Recodify existing 4.-5. as **5.-6.** (No change in text.)

[6.] **7.** The contractor shall submit quarterly reports on [Pharmacy] **Provider** Lock-in participants, as determined by the DMAHS.

SUBCHAPTER 2. CRITERIA FOR CONTRACTING WITH THE DEPARTMENT

10:74-2.1 Contract requirements

(a) The contractor shall:

1.-4. (No change.)

5. Assure that the provider network used for private, commercial business be equally available to [Medicaid or NJ] **Medicaid/NJ** FamilyCare enrollees. Such provider network shall consist of hospitals, physicians, dentists, laboratories**,** and all other providers of services covered under the contract, and shall ensure that the providers meet, at a minimum, all standards of practice and credentialing as required by Title XIX Medicaid and Title XXI of the Social Security Act, and shall maintain a comprehensive network of providers sufficient to meet the needs of the general population within the counties in which the MCO has a certificate of authority to operate;

6.-7. (No change.)

8. Have the organizational and administrative capabilities to carry out its duties and responsibilities, which shall include, at a minimum, the following:

i. A [full time] **full-time** administrator to manage day-to-day business activities of the contractor and to be the responsible contract officer. (This does not require a [full time] **full-time** administrator to be dedicated solely to the [Medicaid] **Medicaid/NJ FamilyCare** contract.);

ii.-iv. (No change.)

9. (No change.)

10. Comply with eligibility requirements of the program, which shall include, but shall not be limited to, enrolling only individuals who are covered under specified [Medicaid or NJ] **Medicaid/NJ** FamilyCare categories of assistance;

11.-15. (No change.)

(b)-(d) (No change.)

SUBCHAPTER 3. BENEFITS

10:74-3.1 Scope of benefits

(a) (No change.)

(b) Under the risk contract, all MCO/managed health care contractors shall provide standard service packages as detailed in the managed care contract, which shall exactly equal the services included in the New Jersey [Medicaid] **Medicaid/NJ FamilyCare** program in amount, duration**,** and scope of services [with the exception of NJ FamilyCare-Plan D].

(c) (No change.)

10:74-3.2 Responsibilities of the contractor

(a)-(b) (No change.)

(c) The contractor shall provide EPSDT services for all [Medicaid and NJ] **Medicaid/NJ** FamilyCare-Plan A enrollees under 21 years of age in accordance with the protocols approved by the Division as follows:

1. Initial and periodic treatments shall be provided. All further treatments indicated shall be provided in an appropriate and timely manner and shall be appropriately documented as specified by EPSDT requirements. The above shall be provided in accordance with EPSDT requirements as specified at 42 U.S.C. § 1396d(r) and 42 CFR 441.50 through 441.62. The above shall be provided for [Medicaid and NJ] **Medicaid/NJ** FamilyCare-Plan A beneficiaries only. EPSDT treatment services shall be limited to services covered under the managed care contract for [NJ Family-Care] **Medicaid/NJ FamilyCare** Plans B**,** [and] C**, and D** enrollees and services specified under the fee-for-service program.

2. (No change.)

(d) (No change.)

10:74-3.3 Managed care organization (MCO) benefits for [Medicaid and NJ] **Medicaid/NJ** FamilyCare-Plans A, B**,** [and] C**, and D** enrollees

(a) The MCO shall provide all services required by the managed care contract, including, but not limited to, the services listed in (a)1 through 27 below and at N.J.A.C. 10:49-5, for all [Medicaid and NJ] **Medicaid/NJ** FamilyCare-Plans A, B**,** [and] C**, and D** enrollees, with the exception of those services identified as fee-for-service (see N.J.A.C. 10:74-3.4) or excluded from the specific service package under N.J.A.C. 10:74-3.5:

1.-2. (No change.)

3. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program services:

i. For NJ FamilyCare-Plans B**,** [and] C**, and D** participants, coverage shall include EPSDT: medical examinations, dental, vision, hearing, and lead screening services. Coverage includes only those treatment services identified through the examination that are available under the MCO's benefits package for Plans B**,** [and] C**, and D** enrollees or as services specified under the FFS program;

4.-8. (No change.)

9. Prescription drugs, including legend drugs and non-legend drugs that are covered by the [Medicaid] **Medicaid/NJ FamilyCare** program and indicated in the managed care contract;

10.-19. (No change.)

20. Durable medical equipment (DME)/assistive technology devices in accordance with existing [Medicaid] **Medicaid/NJ FamilyCare** rules (see N.J.A.C. 10:59);

21.-23. (No change.)

24. Organ transplants, which include donor and recipient costs, except that the [Medicaid] **Medicaid/NJ FamilyCare** fee-for-service program will reimburse for transplant-related donor and recipient inpatient hospital costs for an individual placed on a transplant list while in the fee-for-service [Medicaid] **Medicaid/NJ FamilyCare** program prior to initial enrollment into an MCO;

25. (No change.)

26. Nursing [Facility] **Facility/Special Care Nursing Facility (NF/SCNF)** Services—[limited to first 30 days of admission to a nursing facility] **NF/SCNF services shall be covered for all Medicaid, NJ FamilyCare–Plan A, and NJ FamilyCare Alternative Benefit Plan (ABP) enrollees**. This covered benefit is limited to rehabilitation services for NJ FamilyCare - Plan B**,** [and] C**, and D** enrollees; [and]

27. Mental health/substance [abuse] **use disorder** services only for **MLTSS** enrollees **and those enrollees** who are clients of the Division of Developmental Disabilities[. Partial care and partial hospitalization services are covered fee-for-service and are not covered by the MCO.] **(DDD) or a Fully Integrated Dual Special Needs Program (FIDE-SNP) program;**

28. Partial care and partial hospitalization services (except for DDD clients); and

29. Inpatient mental health and substance use disorder treatment services.

10:74-3.4 Fee-for-service program services requiring MCO assistance to [Medicaid and NJ] **Medicaid/NJ** FamilyCare-Plans A, B**,** [and] C**, and D** enrollees to access the services

(a) The following services shall be provided to Plans A, B**,** [and] C**, and D** enrollees through the Medicaid/NJ FamilyCare fee-for-service program and may necessitate contractor assistance to the enrollee (such as**, for example, providing** medical orders) to access the services:

1. Personal care assistant services (not covered for [NJ] **Medicaid/NJ** FamilyCare-Plans B**,** [and] C**, and D unless enrolled in MLTSS**);

2. Medical day care (not covered for [NJ] **Medicaid/NJ** FamilyCare-Plans B**,** [and] C**, and D unless enrolled in MLTSS**);

3. Outpatient rehabilitation services, including physical, occupational**,** and speech/language therapy [(for Plans B and C, limited to 60 days per therapy per calendar year)];

4. (No change.)

5. Transportation, lower mode [(not covered for NJ FamilyCare-Plans B and C)];

6. (No change.)

7. Services provided by DHS mental health/substance abuse and [DYFS] **CP&P** residential facilities or group homes;

8.-9. (No change.)

10. Prescription drugs (legend and non-legend covered by the [Medicaid] **Medicaid/NJ FamilyCare** program) for the aged, blind**,** or disabled.

10:74-3.5 Fee-for-service services for [Medicaid and NJ] **Medicaid/NJ** FamilyCare-Plans A, B**,** [and] C**, and D** enrollees not requiring case management by the MCO

(a) The following services shall be provided to Plans A, B**,** [and] C**, and D** enrollees through the Medicaid/NJ FamilyCare fee-for-service program without requiring case management by the MCO:

1. (No change.)

[2. ICF/MR services (not covered for NJ FamilyCare-Plans B and C);

3. Waiver and demonstration program services (not covered for NJ FamilyCare-Plans B and C);]

[4.] **2.** [Mental] **Outpatient mental** health services for non-DDD clients**, non-MLTSS clients, and non-Fully Integrated Dual Eligible Special Needs Program (FIDE-SNP) clients**;

[5.] **3.** [Substance abuse] **Outpatient substance use disorder** services for non-DDD clients**, non-MLTSS clients, and non-Fully Integrated Dual Eligible Special Needs Program (FIDE-SNP) clients**:

i.-iii. (No change.)

[6.] **4.** Drugs paid fee-for-service by the [Medicaid] **Medicaid/NJ FamilyCare** program:

i.-iii. (No change.)

iv. Generically-equivalent drug products of the drugs listed above[.]**; and**

[7.] **5.** Family planning services and supplies when furnished by a non-MCO-participating provider[;]**.**

[8. Up to 12 inpatient hospital days for social necessity (not covered for NJ FamilyCare-Plans B and C); and

9. Division of Developmental Disabilities Community Care Waiver (DDD/CCW) waiver services and demonstration program services. These are covered for NJ FamilyCare-Plan A enrollees only.]

(b) The following services shall be provided to NJ FamilyCare beneficiaries enrolled in Plan A and/or the Alternative Benefit Program through the Medicaid/NJ FamilyCare fee-for-service program without requiring case management by the MCO:

1. Intermediate care facilities/individuals with intellectual disabilities (ICF/IID) services;

2. Waiver and demonstration program services; and

3. Division of Developmental Disabilities Community Care Program (DDD/CCP) services.

10:74-3.6, 3.7, and 3.8 (Reserved)

10:74-3.9 General [Medicaid and NJ] **Medicaid/NJ** FamilyCare program limitations

(a) The following service requirements and limitations shall apply in the standard service package or capitation payments, even if provided by the MCO:

1. Although services of podiatrists shall be provided, New Jersey [Medicaid] **Medicaid/NJ FamilyCare** does not ordinarily cover routine foot care or treatment of flat foot conditions. These services shall be provided only when medical necessity is determined.

2. (No change.)

3. Elective/induced abortions are not covered under an MCO program but will continue to be paid on a fee-for-service basis by the [Medicaid and NJ] **Medicaid/NJ** FamilyCare program.

10:74-3.10 General [Medicaid and NJ] **Medicaid/NJ** FamilyCare program exclusions

(a) (No change.)

10:74-3.12 Availability of services

(a) (No change.)

(b) Each contractor shall ensure that no distinctions will be made with regard to quality of service or availability of covered benefits between [Medicaid and NJ] **Medicaid/NJ** FamilyCare enrollees under this subchapter and any other parties served by the contractor.

(c) Each [Medicaid and NJ] **Medicaid/NJ** FamilyCare enrollee shall be given the choice of a primary care provider who will supervise and coordinate his or her care.

(d) Generally, the contractor shall have only one enrollment area for all [Medicaid or NJ] **Medicaid/NJ** FamilyCare parties served, including those served under these regulations. Modifications of such enrollment area for purposes of contracting under this subchapter shall be achieved by means of contract amendment.

SUBCHAPTER 4. MARKETING

10:74-4.1 Marketing

(a) The contractor shall obtain written approval from the Division prior to the commencement of marketing activities, regarding the form and content of the following:

1. Informational and instructional materials to be distributed to inform [Medicaid and NJ] **Medicaid/NJ** FamilyCare enrollees of the scope and nature of benefits provided by the contractor;

2. Informational and instructional materials to be distributed to inform [Medicaid and NJ] **Medicaid/NJ** FamilyCare enrollees of changes in program scope or administration;

3. Public information releases pertaining to the enrollment of [Medicaid and NJ] **Medicaid/NJ** FamilyCare individuals in the contractor's plan; and

4. (No change.)

(b) The contractor shall ensure that:

1.-5. (No change.)

6. None of the contractor's marketing representatives offer or give any form of compensation or reward as an inducement to a [Medicaid or NJ] **Medicaid/NJ** FamilyCare beneficiary to enroll in the contractor's plan. However, for marketing purposes, the MCO may offer health-related promotional giveaways that shall not exceed $15.00 per item and non-health-related promotional giveaways that shall not exceed $10.00 per item, the combined total value of both health related and non-health related promotional giveaways shall not exceed $50.00 in the aggregate annually per individual;

7.-8. (No change.)

SUBCHAPTER 5. INFORMATION PROVIDED TO ENROLLEES

10:74-5.1 Information to be provided to the enrollees by the contractor

(a) At such time as a [Medicaid or NJ] **Medicaid/NJ** FamilyCare beneficiary signs an enrollment application of an MCO, the contractor shall inform the beneficiary that:

1. (No change.)

2. During this interim period, the [Medicaid or NJ] **Medicaid/NJ** FamilyCare-Plan A only enrollee may continue to receive health services under his or her current arrangement as long as he or she retains [Medicaid or NJ] **Medicaid/NJ** FamilyCare-Plan A eligibility; and

3. Subject to the termination of [Medicaid or NJ] **Medicaid/NJ** FamilyCare eligibility, the disenrollment rules in N.J.A.C. 10:74-7 and the termination provisions in the contract between the contractor and the Department, the initial enrollment period shall extend for one year.

(b) (No change.)

(c) Prior to, but not later than, the effective date of coverage, or as specified in the contract, the MCO shall provide the following in writing to a new enrollee:

1.-9. (No change.)

10. An explanation of how to obtain noncovered MCO services that are [Medicaid or NJ] **Medicaid/NJ** FamilyCare benefits.

(d) (No change.)

SUBCHAPTER 6. GENERAL ENROLLMENT

10:74-6.1 Enrollment

(a) Prior to implementation, the contractor shall obtain written approval from the Division of the method of enrollment and the enrollment forms to be used in enrolling [Medicaid or NJ] **Medicaid/NJ** FamilyCare beneficiaries. The contractor shall adhere to the enrollment procedures required by the Division and detailed in the MCO contract.

(b) The contractor shall enroll [Medicaid or NJ] **Medicaid/NJ** FamilyCare beneficiaries in the order in which they apply, or are assigned by the Division (in those [Medicaid] **Medicaid/NJ FamilyCare** and Plan A cases where a selection is not made) without restrictions, up to contract limits.

(c) Enrollment shall be for the entire [Medicaid or NJ] **Medicaid/NJ** FamilyCare "case" (family household).

(d)-(e) (No change.)

(f) [Medicaid and NJ] **Medicaid/NJ** FamilyCare-Plan A enrollees shall be subject to a 12-month enrollment lock-in period and may initiate disenrollment/MCO transfer during the first three months after the effective date of initial managed care enrollment and every 12 months thereafter without cause.

(g) All other [NJ] **Medicaid/NJ** FamilyCare enrollees (non-Plan A) shall be subject to a 12-month enrollment lock-in period.

(h) Enrollment lock-in shall not apply to beneficiaries who are aged, blind**,** and disabled, clients of DDD**,** or to [DYFS] **CP&P** clients.

SUBCHAPTER 7. DISENROLLMENT

10:74-7.1 Disenrollment

(a) Disenrollment shall occur:

1. Upon death or whenever the enrollee is no longer [Medicaid or NJ] **Medicaid/NJ** FamilyCare eligible, unless otherwise specified in the contract;

2. Except for the aged, blind**,** or disabled populations, whenever the enrollee moves outside of the MCO's enrollment area boundaries. The contractor shall remain responsible for the enrollee's care until the individual or the family/case has been disenrolled from the plan. Moving from the MCO's enrollment area does not negate a plan's responsibility to provide [Medicaid or NJ] **Medicaid/NJ** FamilyCare benefits. If a plan is aware that a beneficiary who is not aged, blind**,** or disabled is residing outside its enrollment area, the contractor shall ask DMAHS to disenroll the beneficiary due to the change of residence;

3. Whenever the enrollee is admitted to a Residential Treatment Center [(except a DYFS Residential Treatment Center), ICF/MR or long-term psychiatric facility];

4.-5. (No change.)

6. Whenever a [NJ] **Medicaid/NJ** FamilyCare enrollee **who was determined eligible under NJ FamilyCare-Children's Program** attains the age of 19 years;

7. Whenever a [NJ] **Medicaid/NJ** FamilyCare enrollee becomes ineligible due to other health insurance coverage; or

8. Whenever a [NJ] **Medicaid/NJ** FamilyCare-Plans B, C**,** or D participant loses program eligibility in accordance with N.J.A.C. 10:79-7.1.

(b) A [Medicaid or NJ] **Medicaid/NJ** FamilyCare-Plan A enrollee may elect to disenroll from the contractor's plan at any time during the first 90 days of an initial period of enrollment in an MCO and once every 12 months after the initial period of managed care enrollment without the need to state a cause.

(c) After the first 90-day period and for the remainder of the enrollment period, a [Medicaid or NJ] **Medicaid/NJ** FamilyCare enrollee may elect to disenroll, with cause, at any time. Good cause shall be determined on a case-by-case basis, upon notification to the HBC. Good cause reasons may include, but are not limited to, failure of the contractor to provide services to the enrollee, failure of the contractor to respond to an enrollee's grievance, enrollee is qualified for an enrollment exemption, or enrollee has more convenient access to a PCP/APN in another MCO. Such information shall be made available to the enrollee by the contractor MCO and/or the health benefits coordinator.

1. [Medicaid and NJ] **Medicaid/NJ** FamilyCare [(NJFC)] enrollees subject to mandatory enrollment shall transfer to another participating MCO upon disenrollment from a contractor's plan.

(d) (No change.)

(e) Beneficiaries receiving services in [a waiver program or a demonstration program, or treatment in a nursing facility exceeding 30 days,] or admitted to a long-term psychiatric hospital or facility, or an [ICF/MR] **ICF/IID** shall be disenrolled from the managed care entity on the date of admission to the facility [or enrollment into the waiver or demonstration program or at the end of the 30th day in a nursing facility. Nursing facility days accrue when an enrollee is transferred directly to an acute hospital with disenrollment only upon and on the date of direct admission back into a nursing facility].

SUBCHAPTER 8. ENROLLEES

10:74-8.1 Mandatory managed care enrollment

(a) (No change.)

(b) The following [Medicaid and NJ] **Medicaid/NJ** FamilyCare-Plan A eligibility groups shall enroll in a managed care organization:

1.-8. (No change.)

9. Children under [DYFS] **CP&P** supervision in foster care.

(c) (No change.)

10:74-8.2 Enrollment exclusions

(a) The following persons shall be excluded from enrollment in the managed care program:

[1. Individuals in the following Home or Community-based Waiver programs, including Model Waiver I, Model Waiver II, Model Waiver III, Enhanced Community Options Waiver (ECO), Assisted Living/Alternate Family Care Waiver, Aids Community Care Alternative Program (ACCAP); Community Care Program for Elderly and Disabled (CCPED); ABC Waiver for Children, and Traumatic Brain Injury (TBI);

2. Individuals in a Medicaid demonstration program;]

[3.] **1**. (No change in text.)

[4.] **2**. Individuals in the Medically Needy, Presumptive Eligibility for pregnant women, presumptive eligibility for children under the [Medicaid or NJ] **Medicaid/NJ** FamilyCare programs, [Home Care Expansion Program,] or the PACE Program;

[5.] **3**. (No change in text.)

[6. Individuals already enrolled in or covered by a Medicare or private MCO that does not have a contract with the Department to provide Medicaid services;]

[7.] **4**. (No change in text.)

[8.] **5**. [Full time] **Full-time** students attending school and residing out of the country while in school; **and**

[9.] **6**. The following types of dual beneficiaries: Qualified Medicare Beneficiaries not otherwise eligible for Medicaid[;]**,** Special Low-Income Medicare Beneficiaries (SLMBs)[;]**,** Qualified Disabled and Working Individuals (QDWIs)[;]**,** and Qualifying Individuals 1 and 2 (QIs 1 and 2)[; and]**.**

[10. DYFS Code 65 individuals.]

10:74-8.3 Voluntary managed care enrollment (allowed and not allowed)

(a) The following individuals shall be excluded from the automatic assignment process but may enroll voluntarily:

1.-5. (No change.)

6. Individuals eligible through [the Division of Youth and Family Services] **Child Protection and Permanency (CP&P)** who are not in foster care:

i. All individuals eligible through [DYFS] **CP&P** shall be considered a unique case and shall be issued an individual [12 digit] **12-digit** identification number and shall be enrolled in his or her own right.

7. (No change.)

8. Individuals identified as having more than one active eligible [Medicaid] **Medicaid/NJ FamilyCare** number; and

9. (No change.)

(b) (No change.)

10:74-8.4 (Reserved)

10:74-8.5 Coverage prior to enrollment

If the beneficiary needs [Medicaid or NJ] **Medicaid/NJ** FamilyCare-Plan A covered services from the date of eligibility prior to the completion of the enrollment process, care shall be given by fee-for-service providers enrolled in the New Jersey [Medicaid or NJ] **Medicaid/NJ** FamilyCare program. These providers shall bill [Medicaid or NJ] **Medicaid/NJ** FamilyCare under the normal fee-for-service system, in accordance with N.J.A.C. 10:49-8.

10:74-8.7 Protecting managed care enrollees against liability for payment

(a) If a fee-for-service or managed care provider, whether or not a participant in a program administered in whole or in part by the Division of Medical Assistance and Health Services (DMAHS), renders a covered service to a beneficiary of a program administered in whole or in part by DMAHS, including, but not limited to, the WorkFirst NJ/General Assistance, [Medicaid or NJ] **Medicaid/NJ** FamilyCare program, the provider's sole recourse for payment, other than collection of any authorized cost-sharing and/or third-party liability, shall be either DMAHS or the MCO with which DMAHS contracts that serves the beneficiary. A provider shall not seek payment from, and shall not institute or cause the initiation of collection proceedings or litigation against, a beneficiary, a beneficiary's family member, any legal representative of the beneficiary or anyone else acting on the beneficiary's behalf unless (a)1 below, or (a)2 through and including 7[,] below, apply:

1.-7. (No change.)

SUBCHAPTER 9. EMERGENCY SERVICES

10:74-9.1 Emergency services

(a)-(e) (No change.)

(f) The contractor shall pay for all medical screening services rendered to its members by hospitals and emergency room physicians. The amount and method of reimbursement for medical screenings shall be subject to negotiations between the contractor and the hospital and directly with non-hospital-salaried emergency room physicians and shall include reimbursement for urgent care and non-urgent care rates. Non-participating hospitals may be reimbursed for hospital costs at [Medicaid] **Medicaid/NJ FamilyCare** rates or other mutually agreeable rates for medical screening services. Additional fees for additional services may be included at the discretion of the contractor and the hospital.

1.-2. (No change.)

(g)-(k) (No change.)

(l) As required by 42 U.S.C. § 1396u-2(b)(2)(D), all non-participating providers of emergency services including, but not limited to, non-contracted hospitals providing emergency services to [Medicaid or NJ] **Medicaid/NJ** FamilyCare members enrolled in the managed care program, shall accept, as payment in full, the amounts that the non-

contracted providers and/or hospitals would receive from [Medicaid] **Medicaid/NJ FamilyCare** for the emergency services and/or any related hospitalization as if the beneficiary were enrolled in FFS Medicaid.

SUBCHAPTER 10. MEDICAL INFORMATION AND QUALITY ASSURANCE

10:74-10.2 Quality assurance

(a)-(b) (No change.)

(c) The contractor shall submit to the Division for approval a detailed plan for establishing and maintaining an internal quality assurance system to assure that acceptable professional practice shall be followed by the organization and its subcontractors. This shall include a proposed system for continuing performance review and health care evaluation, that is, explanation of the methods [which] **that** the contractor proposes to follow in guaranteeing that the services provided each enrollee shall meet criteria established by appropriate Federal and State statutes and regulations. (See 42 [C.F.R.] **CFR** Part 438.)

1. The contractor shall include in the written agreement with the subcontractor, the requirement that a subcontractor be prohibited from further subcontracting any of the obligations that they agreed to meet.

(d)-(e) (No change.)

SUBCHAPTER 11. GRIEVANCE PROCEDURE

10:74-11.2 [Medicaid] **Medicaid/NJ FamilyCare** fair hearing

(a)-(c) (No change.)

SUBCHAPTER 12. REIMBURSEMENT

10:74-12.1 Contractor compensation

(a) Compensation to the contractor for MCO enrollees shall consist of monthly capitation payments for each enrollee. These payments shall be for a defined scope of services to be furnished to a defined number of enrollees, for providing the services contained in the Benefits Package as described in N.J.A.C. 10:74-3. Such payments shall be actuarially sound and in accordance with 42 CFR 438.6, incorporated herein by reference, as amended and supplemented. In addition, supplemental fee-for-service payments may be made to the contractor for certain services, which shall be specified by contract in a manner determined by the Division of Medical Assistance and Health Services. In addition, certain high-cost, low-utilized drugs and blood products costs as specified by contract will be reimbursed to the MCO at the lesser of their cost or the current [Medicaid] **Medicaid/NJ FamilyCare** fee-for-service payment amount.

(b)-(c) (No change.)

SUBCHAPTER 13. GENERAL REPORTING REQUIREMENTS

10:74-13.1 Reporting requirements

(a) (No change.)

(b) The contractor shall submit to the Division at least annually**,** information specified by the Division on [non-Medicaid] **non-Medicaid/NJ FamilyCare** enrollees for purposes of comparative analyses of service use and cost patterns.

(c)-(h) (No change.)

TRANSPORTATION

(a)

MOTOR VEHICLE COMMISSION

Enforcement Service

Diesel Vehicle Inspection

Proposed Amendments: N.J.A.C. 13:20-7.3, 46.1, 46.2, 46.3, and 46.6

Authorized By: Motor Vehicle Commission, B. Sue Fulton, Chair and Chief Administrator.

Authority: N.J.S.A. 39:2-3, 39:2A-28, and 39:8-40.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2019-039.

Submit comments by May 31, 2019, to:

Kate Tasch, APO
Motor Vehicle Commission
225 East State Street
PO Box 162
Trenton, NJ 08666-0162
e-mail: rulecomments@mvc.nj.gov

The agency proposal follows:

Summary

The public comment period for this notice of proposal will be 60 days, since the notice of proposal is not listed in an agency rulemaking calendar. Therefore, this notice of proposal is excepted from the rulemaking calendar requirements, pursuant to N.J.A.C. 1:30-3.3(a).

The Motor Vehicle Commission ("MVC" or "Commission") proposes amendments to the diesel vehicle inspection rules. The proposed amendments would include diesel vehicles weighing over 8,500 pounds, commonly referred to as medium-duty diesel vehicles, in the MVC's roadside inspection program.

N.J.A.C. 13:20-7.3, Inspection facilities, is proposed for amendment to include diesel powered vehicles in the categories of vehicles inspected at State specialty inspection facilities, to be inspected when the diesel vehicles over 8,500 pounds have failed a roadside inspection for tampering.

N.J.A.C. 13:20-46.1, Definitions, is proposed for amendment to include a definition of "diesel powered motor vehicles," which includes vehicles over 8,500 pounds that are designed or used for construction or farming purposes. Also included is a definition of "State specialty inspection facility."

N.J.A.C. 13:20-46.2, Diesel emission inspection requirements; exempt vehicles, is proposed for amendment to include diesel powered motor vehicles.

N.J.A.C. 13:20-46.3, Roadside inspections; scope; inspection procedures, is proposed for amendment to include diesel powered motor vehicles in the roadside emissions inspection program.

N.J.A.C. 13:20-46.6, Civil penalty; schedule, reduction of penalty, is proposed for amendment to add diesel powered vehicles to heavy-duty diesel trucks and diesel buses, subjecting them to penalty if operated in violation of N.J.S.A. 39:8-62. The section prescribes penalties for first and subsequent violations.

Proposed new N.J.A.C. 13:20-46.6(k) is added to subject diesel powered vehicles to a re-inspection at a State specialty inspection facility if any owner or lessee of such a vehicle disconnects, detaches, or deactivates or in any way renders inoperable, any element of the exhaust system. Diesel powered motor vehicles that fail to meet diesel emission standards shall have 45 days to be repaired in order to legally operate in New Jersey.

Social Impact

The proposed amendments are anticipated to have a positive social impact. Including additional diesel powered vehicles in the MVC's roadside inspection program should give the motoring public reassurance that diesel vehicles emitting smoke are being inspected.